CDSMP Participant Intake Form

HEALTH BEHAVIOR AND ASSESSMENT INTERVENTION (HBAI)

Section 1: PARTICIPANT INFORMATION:

Name_____

Address: _____

Home phone: _____ Cell/other phone: _____

Best time to call: _____ Birth Date: _____Male Female

Participant's primary language: _____

Race/ethnicity: _____ Latino/Latina

Workshop Site Assigned: _____

Workshop Start Date: _____

Class Zero Intake Site: _____

Section 2: BILLING INFORMATION:

Medicare number: _____

Supplement/Advantage plan: _____

Referring Physician: _____

Address: _____
City/State:_____
Phone: _____ Fax: _____

Referral Organization:
_____

Orientation:

Person □

Place □

Time □

Section 3: MEDICAL INFORMATION:

Chronic Disease _____ (Primary)

Chronic Disease _____ (Secondary)

Other
Conditions_____

Age____ Ht_____ Wt_____ BMI___

1. Are you taking oral medications to treat your chronic disease? Yes No

Name(s) of medication and dosage(s):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

2. How often are you physically active (e.g., walking, exercising?)

Never, Rarely, 1–3 times per month Once a week,

Two or more times per week Daily

Please share examples of the types of physical activity:

_____

3. Do you follow a specific meal plan? Yes No

If yes, what is your meal plan?

_____

_____

4. Do you use tobacco? Yes No

If yes, what type? Cigarettes_____ Chew____ Snuff___ Pipe____ Cigar____

If you stopped smoking, when was your last use?_____

5. Do you have pain from your chronic disease or any other condition?
Yes No

If yes, describe how this affects you:

_____

_____

6. Have you been in the emergency room or hospitalized for a condition related to your disease in the last 12 months? Yes No

Details:

_____
_____

Section 4 - SOCIAL FACTORS

Family Environment and Support:

1. Do you live alone? Yes No If no how many people live with you _____

2. Are there relatives or others caring helping you on a regular basis?

   Yes No

3. Do you prepare your own meals? Yes No

If no, who prepares them for you?

_____

4. Do you have support from family or others to deal with your chronic disease?
   Yes No

5. Are there other psychosocial factors impacting your management of your disease? Yes No

If yes, please specify:

_____

Cultural Factors:

1. Is there anything specific to your culture that you think influences your ability to manage your disease?

   _____
   _____

2. Do your cultural beliefs influence your ability to manage your disease?

   _____
   _____

3. Are there certain types of foods important to your culture?

   _____
   _____

4. Does having your serious illness negatively impact your ability to perform or participate in functions that are important for your culture?

   _____
   _____

5. Are there any religious or cultural factors that affect how you eat?

   _____
   _____
   _____
   _____

6. How do you feel about having a chronic disease

   Okay Anxious Angry Alone

   Afraid Sad Depressed

   Overwhelmed Unsure of what to do

   Additional Comments:

   _____
   _____
   _____

7. Are there any other cultural factors that impact the management of your chronic disease? Please specify:

   _____
   _____
   _____

Section 5 -- INDIVIDUAL EDUCATIONAL PLAN

Paraphrase: The Chronic Disease Self-Management workshop meets for 6 weeks and covers a range of topics. Participants in the workshop learn to work on their own, setting goals related to managing their disease.

Now, we're going to create an individual educational plan for you so that you can get the most out of the workshop.

1. Would you like help with any of the following things (Check as many as applicable?)

___ Eating healthier meals/following a healthier meal pattern

___ Increasing my level of physical activity/exercise

___ Increasing my ability to monitor my disease

___ Increasing the support from family or friends

___ Setting an achievable weight loss goal

___ Increasing my understanding of my disease

___ Improving my ability to manage stress and/or emotions that affect my disease

___ Improving my ability to manage my depression

___ Increasing my ability to work with complications from my disease (such as medical issues like neuropathy, vision problems, low energy, mobility problems)

___ Increasing my ability to use the medical system effectively (for example: better communication with my doctors)

___ Increasing my ability to manage barriers to optimal health management

2. Identify the top three problems or issues which impact your ability to manage your chronic disease: (for example, frequent complications; poor diet; unsafe housing; fear of violence; or other factors)

_____
_____
_____

3. Identify barriers to managing your disease successfully: (physical barriers; language; literacy; appropriateness for self-management

_____
_____
_____

INDIVIDUAL PROBLEMS/NEEDS/GOALS:

4. Participant's readiness for change (Pre-contemplative; contemplative; preparation; action; maintenance; relapse)

_____
_____
_____

5. Participant's initial goals

_____
_____
_____

ACCOMMODATION FOR PARTICIPANT'S INDIVIDUAL EDUCATIONAL NEEDS:

Visual/Learning/Mobility/other disability that needs an accommodation:

_____
_____
_____
_____

Summary of Plan:

Chronic Disease Self-Management Group Program _____

- Six Week Group Intervention for disease self-management
- Each Session is 2.5 hours in duration in a group setting
- Targeted intervention to provide participants with the skills to overcome perceived biopsychosocial barriers to disease self-management

Other:

_____

_____

Instructor's Signature (Clinical Psychologist)_____ Date_____

Name: _____ **Date:** _____

FOLLOW UP PLAN

Recommendations:

☐ Dentist ☐ Foot Doctor ☐ Eye Doctor ☐ Quit Smoking
☐ Dietitian ☐ Flu Vaccination ☐ Pneumonia Vaccination
☐ Public Health/Visiting Nurse Visit ☐ Support Group _____
☐ Social Worker ☐ Other _____
☐ Cholesterol ☐ HDL ☐ LDL ☐ Triglycerides
☐ Microalbuminuria ☐ Other _____

Behavior Change Goal:

Specific behavior to be changed _____

How will you change the behavior? _____

_____

_____

How will the behavior change improve your health or quality of life?

_____

_____

_____

Signature _____

FOLLOW UP ASSESSMENT

How successful are you with your behavior change goal?
☐ Never ☐ Sometimes ☐ Usually ☐ Always

If you are not always successful, why not?

_____

_____

_____

Did you follow through with recommendations? (see above) ☐ Yes ☐ No

If not, why not? _____

_____

_____

How is your current health?
☐ Poor ☐ Fair ☐ Good ☐ Excellent

How often do you follow your meal plan?
☐ N/A ☐ Rarely or never ☐ Occasionally ☐ Often ☐ Always

If you do not always follow your meal plan, why not?

_____
_____
_____

How often are you physically active? _____

How well do you feel you are able to do the take your home medication as prescribed by your doctor(s)

☐ N/A ☐ Poor ☐ Fair ☐ Good ☐ Excellent

How sure are you that you can manage your chronic disease?
☐ Not sure ☐ Somewhat sure ☐ Very sure

My chronic disease is a(n):
☐ Disaster ☐Burden ☐Problem ☐Challenge ☐Opportunity ☐Other

Write one example of how you used what you learned about self-managing chronic disease in your class:

_____
_____
_____

What has changed in your chronic disease care since the classes?

_____
_____
_____

FOR INSTRUCTIONAL STAFF ONLY

Additional interventions provided/follow-up needed

☐ See Education Record: _____

Signature: _____

DATE	PROGRESS NOTES